New Patient Intake Form

Today's Date____/____/____

Name SS# Birthdate / /
Marital Status Age
Address ❑M ❑F Ht Wt
City, State, Zip
Home Phone Work Phone Occupation
Emergency Contact Name & Phone
Referred by
Reason for visit today Have you had acupuncture before? ❑ Yes ❑ No Chinese herbal medicine? ❑ Yes ❑ No
How long have you had this condition?
Is it getting worse? Does it bother your: ❑ Sleep ❑ Work ❑ Other (what?)
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? ❑ Yes ❑ No If yes, for what?
Who is your physician? Physician's Phone
Other concurrent therapies

Health Insurance Info:
Insurance Co. Name Policy #
Address Phone
City, State, Zip

Medicare Info:
Insurance Co. Name Policy #
Address Phone
City, State, Zip

Family Medical History

❑ Allergies
_____
_____
❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism
❑ Cancer
_____
_____
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Seizures
❑ Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

❑ AIDs/HIV
❑ Alcholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox
❑ Diabetes
❑ Emphy sema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitus
❑ Herpes
❑ High Blood Pressure
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Stroke
❑ Surgery (list)
_____
_____
_____
❑ Thyroid Disorders
❑ Major Trauma (Car, fall, etc--list)
_____
_____
_____
❑ Tuberculosis
❑ Typhoid Fever
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough
❑ Other (Specify)
_____
_____
_____
_____

Your Diet

Appetite ❑ Low ❑ High
❑ Coffee
❑ Soft Drinks
❑ Artificial Sweetener
❑ Sugar
❑ Salty Food
Thirst for water: # glasses per day:_____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in last 2 months:
Vitamins/supplements taken in last 2 months:

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational Hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (describe)

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm

Color of phlegm_____

- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions

Other head or neck problems

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Cough

Wet or Dry?_____
Thick or thin?_____

Color of phlegm_____

- ❑ Coughing blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoid
- ❑ Anal fissures

Bowel movements:
Frequency_____ Texture/form_____
Color_____ Odor_____

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other (describe)

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections

Other hair or skin problems

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing a therapist

Other (specify)

Genito-urinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began

Length of cycle (day 1 to day 1)

- ❑ Duration of flow
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge (color)_____
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots

- ❑ Breast lumps

Pregnancies_____
Live births_____
Premature births_____
Age at Menopause_____

Date of last PAP

Date last period began

Other

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Oriental medicine has a great deal to offer as a health care system, however it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

WE, THE UNDERSIGNED, AFFIRM THAT *(X)*_____**(Patient) HAS BEEN ADVISED BY** ***Peter Scolaro*** **(Licensed Acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.**

*X*_____ *X*_____
Patient Signature Date

_____ _____
Licensed Acupuncturist Signature Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatment and other procedures associated with the practice of traditional Oriental medicine provided by the clinical staff (Licensed Acupuncturists or Massage Therapists). I have discussed the nature and purpose of my treatment with the clinical staff.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as massage.

I have been informed that acupuncture is a safe method of treatment, but that it may have effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. I understand that I must indicate if I have any bleeding or bruising disorders or are taking blood thinners, as this will affect the course of treatment. I understand that I must indicate if I am allergic to silicon, latex, or vinyl products, as this will affect the course of treatment.

Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that I must indicate if I have diabetes, as this will affect the course of treatment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I will notify the clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interests.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient (or patient's representative If a minor or physically or legally incapable).

*X*_____
Date consent completed

*X*_____
Print name of patient

*X*_____
Signature of patient or representative

*X*_____
Print name of patient representative (if applicable)

To be completed by the member of The clinical staff providing care.

Peter Scolaro
Print name of clinical staff

_____
Signature of clinical staff

Peter Scolaro, L.Ac.
New York State Licensed Acupuncturist

PATIENT CONSENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Practice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a0 a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any of the changes that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all my questions have been answered to my full satisfaction in a way that I can clearly understand:

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship

Date Signed _____ Witness:_____